

***United States Court of Appeals  
for the Second Circuit***



**BRIEF FOR  
APPELLEE**





Original  
77-7097

IN THE  
**United States Court of Appeals**  
FOR THE SECOND CIRCUIT

THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, a New York not-for-profit corporation, MORTON M. KOFF, M.D., MILTON ROSENBERG, M.D., JANE DOE, and RAYMOND ORTEGA, a seventeen year old infant, by his next friend and parent, RICARDA ORTEGA,

*Plaintiffs-Appellees,*

—against—

PHILIP TOIA, as Commissioner of the Department of Social Services of the State of New York and ROBERT P. WHALEN, M.D., as Commissioner of the Department of Health of the State of New York,

*Defendants-Appellants.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE  
EASTERN DISTRICT OF NEW YORK

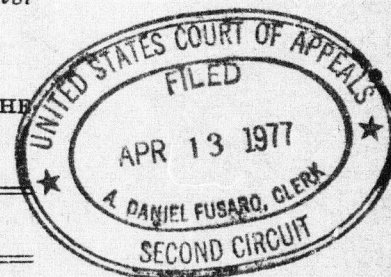
**BRIEF FOR PLAINTIFFS-APPELLEES**

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April 13, 1977





UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

----- x  
THE MEDICAL SOCIETY OF THE STATE OF :  
NEW YORK, a New York not-for-profit :  
corporation, MORTON M. KOFF, M.D., :  
MILTON ROSENBERG, M.D., JANE DOE, and :  
RAYMOND ORTEGA, a seventeen year old :  
infant, by his next friend and parent, :  
RICARDA ORTEGA, :

Plaintiffs-Appellees, :

Docket No. 77-7097

-against- :

PHILIP TOIA, as Commissioner of the :  
Department of Social Services of the :  
State of New York and ROBERT P. WHALEN, :  
M.D., as Commissioner of the Department :  
of Health of the State of New York, :

Defendants-Appellants. :

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UNITED STATES COURT OF APPEALS  
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MILTON ROSENBERG, M.D., JANE DOE, and :  
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of Health of the State of New York, :

Defendants-Appellants. :

Docket No. 77-7097

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On Appeal from the United States District  
Court for the Eastern District of New York

BRIEF FOR PLAINTIFFS-APPELLEES

Preliminary Statement

This brief is submitted by Plaintiffs-Appellees, The  
Medical Society of the State of New York, Morton M. Koff, M.D.,  
Milton Rosenberg, M.D., Jane Doe and Raymond Ortega in response  
to the brief of Defendants-Appellants, the Commissioners of  
Social Services and Health of the State of New York, which

seeks reversal of an order of preliminary injunction issued by Judge George C. Pratt, United States District Judge for the Eastern District of New York, and entered by the Clerk of that Court on January 25, 1977, based on findings of fact and conclusions of law set forth in Judge Pratt's Memorandum Opinion and Order dated January 18, 1977.\* Pursuant to the terms of that injunction defendants have been restrained during the pendency of this action from enforcing or implementing certain provisions of Chapter 76 of the Laws of New York, 1976, New York Social Services Law §365-a(5)(a)(b)(c) and (e), which deny reimbursement, pursuant to the Federal-State Medicaid program, for necessary but deferrable surgery required by indigent patients otherwise eligible for Medicaid coverage.

#### Statement of the Case

1. Prior Proceedings. This action was commenced on August 5, 1976, by a complaint challenging the constitutionality of certain provisions of Chapter 76 of the Laws of New York, 1976, which amended Section 365-a of the State Social Services Law to eliminate reimbursement under the Federal-State Medicaid program for certain types of medically necessary, but

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\* Judge Pratt's Memorandum Opinion is not yet reported, but is set forth in the Joint Appendix herein at JA. 6-39. Citations in the form "JA." followed by a number are to the designated pages of the Joint Appendix. Judge Pratt's order granting the preliminary injunction appears at JA. 4-5.



deferrable surgery required by indigent patients in New York State. The complaint charged that the denial of Medicaid coverage for necessary but deferrable surgery by operation of the State statute violated plaintiffs' due process, equal protection and 1st Amendment privacy rights and the Supremacy Clause of the United States Constitution.\*

Simultaneously with the filing of the complaint plaintiffs applied for a preliminary injunction and obtained a hearing from Judge Pratt on that application on August 29, 1976.\*\* At that hearing plaintiffs introduced affidavits and testimony\*\*\* of four doctors with regard to the operation of the statute and with regard to the irreparable injury to the patient and doctor plaintiffs which would occur if defendants

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\* A copy of the Complaint appears at JA. 127-144. The Amended Complaint, filed August 20, 1976, appears at JA. 146-164.

\*\* A copy of Judge Pratt's Order to Show Cause together with the affidavits of plaintiffs, Morton M. Koff, M.D. and Milton Rosenberg, M.D., and of plaintiffs' counsel with supporting exhibits, on the basis of which the Order to Show Cause was obtained, appear at JA. 40-125.

\*\*\* The State characterizes this testimony as having been given in deposition form and asserts that no evidentiary hearing was held. Brief at p. 5 The testimony was given in open court following argument on the hearing date. Judge Pratt, with the consent of the parties, relied on the written transcript of the testimony rather than remaining in the hearing room during the taking of testimony. Both sides presented testimony and cross-examined the witnesses presented at the hearing. (JA. 169-229.)

were not enjoined during the pendency of the litigation from enforcing the statute. (JA. 42-122, 169-228.) Affidavits of three non-practicing physicians and two non-medical witnesses and testimony of another non-medical witness were offered by the defendants in opposition to the application at and after the hearing. (JA. 229-338.) On January 18, 1977 Judge Pratt issued his Memorandum Opinion and Order restraining defendants from implementing the provisions of the statute eliminating Medicaid coverage for necessary but deferrable surgery during the pendency of the action. (JA. 6-39.)

On February 15, 1977, the State filed a notice of appeal from Judge Pratt's Order (JA. 3). On March 1, 1977, the State moved for a stay pending appeal which was denied by this Court on March 22, 1977.

2. Introduction. This case involves a New York State statute, enacted March 30, 1976, over the objections of the Federal Department of Health Education and Welfare ("HEW"),\* which denies Medicaid coverage for so-called deferrable surgery required by indigent patients otherwise eligible for Medicaid. New York Social Services Law, §365-a(5).

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\* Copies of two letters of the Regional Office of HEW to the New York State Commissioner of Social Services and to the Governor, dated February 27, 1976 and March 29, 1976, setting forth these objections, appear at JA. 104-115.



Under the State statute, all surgery not required to be performed on an urgent or emergency basis will be denied Medicaid coverage (1) unless it falls within a category of surgery exempted by the State Commissioner of Health from the limitations of Chapter 76 "on the basis of medically indicated risk factors"\* or (2) unless two doctors certify that the

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\* The Commissioner has exercised his powers under the statute to exempt five categories of surgery from the limitations of Chapter 76 "on the basis of medically indicated risk factors." These include cataract surgery to restore vision, eye muscle surgery to correct strabismus (the inability of one eye to attain binocular vision because of muscle imbalance), myringotomy (surgical incision of the ear drum) to preserve hearing, "tubal ligation or vasectomy to interdict conception" and "termination of pregnancy." 10 New York Codes, Rules and Regulations ("NYCRR") §85.2. (JA. 20.)

Plaintiffs objected in their complaint on due process and equal protection grounds (1) to the vagueness of the criterion "medically indicated risk factors" in the context of a statute which elsewhere speaks of many different types of medical risks (e.g., the risk of surgical intervention, the risk of death, the risk of impairing an "essential function") and (2) to the Health Commissioner's arbitrary exercise of his discretion under this provision to exempt vasectomies and voluntary abortions from the limitations on deferrable surgery contained in the statute. As the doctors testified below, there is no distinction in terms of medical risk, however conceived, between vasectomies and many voluntary abortions on the one hand and numerous other surgical procedures which are not exempted on the other. (JA. 51-52, 186-187, 223.) In all events, the doctors testified the use of the phrase, "medically indicated risk factors" in the context of this statute is so ambiguous as to be incomprehensible. (Ibid.) However, Judge Pratt found it unnecessary to reach these issues because of his conclusion that the State statute was invalid under the Supremacy Clause as in conflict with Federal Medicaid law. (JA. 31.)



surgery cannot be deferred for six months without jeopardizing life or "essential function" or causing "severe pain."\* New York Social Services Law §365-a.

Plaintiffs include the Medical Society of the State of New York, a New York State non-profit corporation originally chartered by the State legislature in 1806, Ch. 137, Laws of New York, 1806, with approximately 28,000 New York State physicians as members, which has among its purposes enhancing "the delivery of medical care of high quality to all people in the most economical manner" and promoting "the betterment of community health." Plaintiffs Rosenberg and Koff are physicians licensed to practice in New York State and members of plaintiff Medical Society. Both treat a substantial number of patients covered by Medicaid. Plaintiff Rosenberg specializes in obstetrics and gynecology and performs surgery in connection therewith. Plaintiff Koff practices family medicine and

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\* Plaintiffs also objected in their complaint on due process and equal protection grounds (JA. 140, 143, 160, 163) and offered testimony at the hearing with respect to the vagueness and generality of the expressions "severe pain" and "essential function" when used to distinguish between conditions requiring surgery and those which do not. (JA. 158-159, 185-186, 208-209.) Judge Pratt found it unnecessary to decide this issue because of the conflict he found between the Federal and State Medicaid statutes. (JA. 24-25, 31.)



recommends patients for surgery as part of his practice. Both doctors treat substantial numbers of patients eligible for Medicaid. (JA. 43, 118, 149, 180, 200, 222.)

Plaintiff Raymond Ortega is a seventeen year old youth receiving assistance under the Aid for Dependent Children program who is thereby qualified for Medicaid coverage. At the age of seven Ortega suffered extensive second and third degree burns of his face, neck and chest for which he has received multiple skin grafts. A severe burn scar of the right side of his face has caused an ectropion or stretching of his right lower eyelid and a significant contracture at the angle of the mouth. This condition has been recommended for surgery by the child's physician to arrest further physical debilitation as well as to alleviate the emotional trauma which the scar causes the child. Because of the child's financial circumstances and by reason of Chapter 76, the surgery cannot be performed because the surgery recommended is not urgent or emergency surgery, has not been exempted by the Commissioner of Health and because the child's physician is unable to opine that the surgery cannot be deferred for six months or more without



threatening the child's life or "essential functions"\* and without causing him "severe pain." (JA. 150-152, 180-185.)\*\*

3. The Federal Medicaid Program. The Federal Government currently provides monies to states for the provision of medical assistance to qualified low income and indigent persons pursuant to the joint Federal-State Medicaid program,

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\* The State in its Brief presents a peculiarly abbreviated summary of the testimony of Dr. Edgar Altchek at the hearing with regard to Ortega's condition which entirely distorts its significance in the context of this case:

"Dr. Al[t]chek deposed that plaintiff Ortega had voluntarily sought surgery (A. 183-84), that his condition would cause damage to his eye if not operated on, and that vision is an essential function." Brief at p. 5.

What is omitted from this summary is the vital fact -- from the standpoint of the issues presented by this litigation -- that Dr. Altchek testified that deferral of surgery on Ortega for six months would not threaten his vision although at some later date Ortega's condition will have deteriorated sufficiently to require surgery in order to preserve the child's sight (JA. 182.)

\*\* As a result of continued deterioration of the condition of a second patient-plaintiff (denominated Jane Doe in the complaint in order to preserve her privacy) because of the unavailability of the surgical procedures recommended by her doctor, she has reached a point at which it has become necessary to perform surgery on her on an urgent or emergency basis. The medical condition from which she suffered and the surgical procedures necessary to alleviate it are, however, as the evidence below demonstrated, exceedingly common (JA. 216) and Judge Pratt found in his opinion that the Medical Society had standing to litigate the application of Chapter 76 to other patients in Jane Doe's circumstances. (JA. 19-22.) Her condition was, moreover, one of the many which the evidence below established would be untreated as a result of the statute's operation. (JA. 204-208, 222-226.)



which is governed by Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and the regulations promulgated thereunder. 45 Code of Federal Regulations ("C.F.R.") §§201 et seq.

Section 1901 of the Social Security Act (42 U.S.C. §1396) requires state Medicaid plans to meet the thirty-six separately enumerated requirements of Section 1902 of the Social Security Act. 42 U.S.C. §1396a. Section 1902 provides, as here relevant:

"(a) A State plan for medical assistance must

\* \* \*

(13) provide --

\* \* \*

(C) . . . for the inclusion of at least --

(i) the care and services listed in clauses (1) through (5) of section 1396d(a) of this title...."

Included in (1) through (5) of §1396d(a) are:

"(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);"

and "(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title) [\*], whether furnished in the office,

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\* 42 U.S.C. §1395x(r)(1) reads:

"(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he performs such function or action...."



the patient's home, a hospital, or a skilled nursing facility, or elsewhere;"

The Federal regulations promulgated pursuant to the Federal Medicaid statute also provide that a qualifying state plan must cover "inpatient hospital services," which are defined as "those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician...", (emphasis supplied) 45 C.F.R. §249.10(b)(1), as well as "physicians' services," which are defined as "those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." (Emphasis supplied.) 45 C.F.R. §249.10(b)(5).

Section 6521 of the New York Education Law states: "The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."

4. New York State's Medicaid Program. Since 1966 New York State has had in effect a State Medicaid Program which purports to comply with all Federal requirements, and which authorizes and directs the acceptance of Federal funds under the Federal Medicaid Program. New York Social Services Law §§364-a et seq. The disbursement of funds to aid persons



eligible for medical assistance must be certified as proper for payment by the Department of Social Services. New York Social Services Law, §§365-a, 366-a, and 367. The program in the past has provided for

"...payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his capacity for normal activity, or threaten some significant handicap...." Social Services Law §365-a.

On March 30, 1976 Governor Hugh Carey signed into law Chapter 76 of the Laws of New York, 1976, also known as the Medicaid Cost Containment Legislation (hereinafter "Chapter 76"). Chapter 76 amends Section 364-a et seq. of the New York Social Services Law.

Chapter 76 imposes for the first time limitations on the types of deferrable surgery which will be reimbursed under the State Medicaid plan. Section 3 of that Chapter limits the definition contained in §365-a of the New York Social Services Law of "medicial assistance" reimbursable under Medicaid by adding a new subdivision (5) to that section which reads as follows:

"(5). (a) Medical assistance shall include surgical benefits for emergency or urgent surgery for the alleviation of severe pain, for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated.

"(b) Medical assistance shall include surgical benefits for certain surgical procedures which meet



standards for surgical intervention, as established by the state commissioner of health on the basis of medically indicated risk factors, and medically necessary surgery where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention.

"(c) Medical assistance shall include surgical benefits for other deferrable surgical procedures specified by the state commissioner of health, based on the likelihood that deferral of such procedures for six months or more may jeopardize life or essential function, or cause severe pain; provided, however, such procedures shall be included in the case of in-patient surgery, except surgery authorized pursuant to paragraph (a) of this subdivision, only when a second written opinion is obtained from a physician, or as otherwise prescribed, in accordance with regulations established by the state commissioner of health, that such surgery should not be deferred.

\* \* \*

"(e) Medical assistance shall not include any in-patient surgical procedures or any care, services or supplies related to such surgery other than those authorized by this subdivision."

On March 29, 1976, the Regional Administrator of the Department of Health, Education and Welfare wrote to Governor Carey pointing out the conflicts between the State law and the Federal statute (JA. 111-115):

"Section 3 of the law, amending section 365-a of the Social Services Law would significantly limit surgical benefits reimbursed under Medicaid. The surgical procedures so limited are provided as 'inpatient hospital services' or 'physicians services' which are both mandatory services under a state Medicaid program (cf. sections 1902(a)(13) and 1905(a)(1) and (5) of the Act [42 U.S.C. §§1396a(a)(13) and 1396d(a)(1) and (5)]). Under Medicaid regulations 'inpatient hospital services' are defined as 'those items and



services ordinarily furnished by the hospital for the care and treatment of inpatients...' (emphasis supplied [in original]). 'Physicians services' are defined in the Medicaid regulations as 'services provided, within the scope of practice of his profession as defined by State law...'. Certain surgical procedures -- outside the scope of the limiting amendment -- would be 'ordinarily provided' or still within general state defined physician practices. Accordingly, some surgical procedures and physician services outside the scope of the New York amendment must be provided to Medicaid recipients. Failure to provide these procedures which are mandated by the Act, and Medicaid regulations, would bring into question New York's compliance with federal law. This conflict with federal law would not escape consideration by third parties in any litigation against the State with respect to the surgical cut-backs. [Emphasis supplied.] The limitations on surgical procedures also are inconsistent with the Medicaid regulation at 45 CFR 249.10(a)(5)(i) which provides, in pertinent part,:

"The State may not arbitrarily deny or reduce the amount, duration or scope of such services for an otherwise eligible individual solely because of the diagnosis, type of illness or condition. Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures.'[\*]

"The wording of the New York law eliminating elective and deferrable surgery in all cases unless two doctors certify that a wait of six months or more will jeopardize life or essential function makes reimbursement for mandatory hospital and physician services contingent on diagnosis and type of illness or condition (contrary to the above regulation).

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[\*] Because Judge Pratt found that the State law deprived indigent patients of "physicians' services" and "hospital services" mandated by Federal Medicaid law, he found it unnecessary to consider the additional conflicts between State and Federal law pointed out in HEW's letter and raised in the complaint in this action. (JA. 25-26.)



"Accordingly, the provisions in Section 3 limiting the availability of surgical procedures to specified conditions seems an arbitrary blanket exclusion of mandated services that goes beyond medical necessity or utilization review and violates 45 C.F.R. 249.10(a)(5)(i). In addition such exclusion of beneficial surgical procedures may violate the general requirement of Section 1902(a)(19) that all state plans provide that 'care and services under the plan will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.'"

5. The Conflict between Federal and State Law.

The conflict between Federal and State law pointed out by HEW is plain on the face of the relevant statutes. Under Federal law the State program is to provide "physician's services," 42 U.S.C. §1396a(a)(13), which Federal regulations define as "those services provided, within the scope of practice of his profession as defined by State law..." 45 C.F.R. §249.10(b)(5). New York Education Law §6521 defines the profession of medicine as, inter alia, "treating, operating or prescribing for any human disease, [or] pain, injury, deformity or physical condition." (Emphasis supplied.) Under Chapter 76 the only "pain" for which a doctor may prescribe or operate under Medicaid is that which is or will become "severe" if the surgery is deferred for six months. In those situations in which no pain or threat to life is involved the physician is limited by Chapter 76 to prescribing surgery as necessary to avert a threat to "an essential function," despite the Federal statute's directive that he be permitted to prescribe medically necessary surgery



for any disease, injury deformity or physical condition -- without regard for whether the functions impaired by the disease, injury, deformity or physical condition are "essential" or less than "essential".

Beyond these conflicts apparent on the very face of Federal and State law, there was firm evidentiary support in the record for Judge Pratt's conclusion that in numerous other factual situations New York State's statute denies Medicaid coverage which is mandated by Federal law.

One of these situations is that of plaintiff Raymond Ortega. As established in the testimony at the hearing, surgery was recommended for Raymond Ortega at the clinic in Mt. Sinai Hospital to correct a severe deformity of his face resulting from burns he suffered when he was seven years old. (JA. 8-9, 180-185.) Of immediate concern was an "ectropion" of Ortega's right lower eyelid, which was described by Dr. Edgar Altchek of Mt. Sinai Hospital in his testimony as follows:

"Burn scarring of the cheek pulls down the lower eyelid causing the eyelid to be pulled down, exposing more of the eye, the eyeball than one would like. Such a condition in such a case, the eyelids do not adequately protect the eyeball and the patient can go on to develop severe problems." (JA. 182.)

However, because the condition could in the opinion of the doctor be allowed to continue uncorrected for six months without threatening the youth's eyesight, and since no pain or threat to life was involved, Ortega's admitting physician was

unable to give him the opinion required by Chapter 76 in order to qualify him for reimbursement under Medicaid. (JA. 182-183.) Given Ortega's financial circumstances, he was thus unable to obtain surgery as a result of the State statute, although such surgery would ordinarily be provided by hospitals in New York State for a patient in his situation and would be within the practice of medicine as defined by New York Law. (JA. 181; New York Education Law §6521).

The affidavits and testimony before Judge Pratt also established numerous other factual situations requiring surgery in which the operation of the State statute conflicts with Federal law. Included among these situations are such common medical conditions as bleeding hemorrhoids, lipoma or other benign tumors of the vulva, cystocoele or dropping of the bladder, abnormal menstrual bleeding such as that suffered by plaintiff Jane Doe, and condyloma acumminata or venereal warts. (JA. 47-50, 202-208, 222-226.)

As established by the evidence below, hemorrhoids, consisting of a rupturing of veins in the anal canal which causes swelling and occasional bleeding, is a common complaint among Medicaid patients. This disorder usually results in itching and minor physical discomfort and may cause embarrassing staining of the patient's clothing in the vicinity of the anus. The patient's condition can be corrected by inpatient



surgery. However, deferral of such surgery for six months or more would not normally jeopardize life or essential function of the patient or cause him severe pain. (JA. 47-48, 223-225.)

Lipoma, a benign tumor of the vulva, is a disorder routinely seen by doctors among their Medicaid patients which does not ordinarily cause pain except during sexual intercourse performed in a manner which creates pressure on the tumor. Life and essential function are not jeopardized since both sexual intercourse and reproduction can still occur, and severe pain can be avoided. Nevertheless the condition is commonly the subject of surgical procedures, ordinarily provided by hospitals in New York State to alleviate the condition because of the serious emotional trauma which frequently results from the difficulties which the condition creates in sexual relations. (JA. 48, 225.)

Symptoms of cystocoele or dropping of the bladder, resulting from a relaxation of ligaments retaining urine in the bladder, include loss of urine, consequent odor and staining following minor muscle spasms associated with sneezing, coughing or laughing. The condition in no sense threatens life, typically causes no pain, nor does it jeopardize any essential function. However, the frequently resulting emotional trauma, social and economic dislocations and embarrassment can be eliminated by routine surgical procedures. (JA. 120-121.)

A further common condition affected by Chapter 76 is menstrual bleeding which is abnormal because of its volume and frequency. It is this condition that afflicted Jane Doe. While the condition is neither life-threatening nor such as to jeopardize essential function or cause severe pain, it may proceed to a point where the patient is unable to leave her house for several days every two weeks, as was plaintiff Doe's situation. In such circumstances, where the condition has not responded to other available forms of treatment and when hormone therapy cannot be used because of side effects, surgical removal of the bleeding organ is commonly recommended and performed. (JA. 119-120, 201-216.)

Condyloma Accuminata or venereal warts, growths in and around the vulva, are grossly unsightly and often cause irritation, itching and interruption of normal sexual activities, leading to emotional trauma for the patient. Where such growths are of sufficient size as not to be controllable by drug therapy, surgical procedures are commonly performed to alleviate the undesirable symptoms. (JA. 121, 206.)

Surgery to alleviate each of the medical conditions referred to above is ordinarily available from hospitals in New York State and is part of the practice of medicine by New York doctors as defined by State law. (JA. 47-50, 120-121, 204, 223-224.) Nevertheless, since none of these surgical



procedures are among those designated by defendant Whalen "on the basis of medically indicated risk factors" as permitted deferrable surgery and since the surgical procedures may all be deferred without jeopardy to life or essential function or causing severe pain, plaintiff doctors and doctors of plaintiff patients have been unable to give the opinion necessary to permit the patients to obtain payment for their surgery under Chapter 76. (JA. 7-9, 223-224.)\*

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\* The State, in its highly abbreviated summary of the plaintiff's case before Judge Pratt, sets forth as the reason that the doctors have not given the opinion required by their patients in order to obtain coverage for surgery is not because the facts of their condition will not support the required opinion, but "because they [the doctors] refuse to do the paperwork." Brief at p. 6. This factual attack on the good faith of the doctors testifying below was rejected by Judge Pratt, acting well within his discretion. The Judge found, as a matter of fact, that the reason that the doctors could not give the opinion necessary for their patients to obtain Medicaid coverage was because their medical condition would not support the opinion. (JA. 27-32.) In all events, an examination of the record at the places cited by the State in its Brief as supporting its assertion as to the motivation of the doctors in refusing to give the necessary opinions reveals that the doctors' reference to "paperwork" was in response to a suggestion by the State's attorney that, even though the doctors could not render the first opinion required by the statute, they should nevertheless have submitted the case to a second doctor in an effort to secure his opinion and, thereafter, seek review of any adverse opinion by any second doctor in appellate proceedings within the Department of Health (JA. 209, 226.) The doctors quite appropriately rejected this proposal as "circumventing" the procedures set forth in the statute and adding needless and wasteful paperwork to no avail since they could never comply with the initial requirement of the statute that the proposing doctor certify to the existence of conditions permitting Medicaid compensation for the surgery. (Ibid.)



6. The State's Case Below. The only witness presented by the State for cross-examination at the hearing on Judge Pratt's Order to Show Cause -- a non-doctor who is director of utilization control for the Department of Social Services -- testified that even if Chapter 76 eliminated surgery to the medical conditions referred to by plaintiffs, it would also eliminate such cosmetic surgery as electrolysis, operations to increase breast size, tattoo removal and "unnecessary hysterectomies" for a cost-saving to the State projected by the witness as \$360 million a year or "in the neighborhood of \$1 million a day" of which \$650,000 a day was directly attributable to the cost of the operations. (JA. 242-243.) These figures were, however, thereafter disowned by the State in an affidavit of a Deputy Commissioner of the Department of Social Services, filed after the hearing, setting the cost savings at \$65 million a year (JA. 329), which is the cost-savings figure relied on by the State on this appeal. An examination of the schedule annexed to this affidavit on which the \$65 million figure is apparently based (JA. 332) reveals, however, that this figure should further be reduced by \$45 million to reflect accurately the State's own position at the



hearing as to the cost savings attributable to the only sections of Chapter 76 enjoined by Judge Pratt.\*

Whatever the appropriate cost-savings figure relied on by the State,\*\* the post-hearing affidavit failed to respond to the questions raised by plaintiffs on their cross-examination of the only witness presented by the State at the hearing (JA. 237-239) with respect to the marginal cost savings, if any, properly attributed at Chapter 76 in light of two other essentially duplicative programs for review of the "medical necessity" for hospital admissions, namely, New York State's Hospital Utilization Review Program and Professional Standards Review Organization ("PSRO") program. 42 U.S.C. §1395x(k), 10 NYCRR §721.2; 42 U.S.C. §1320c, 42 C.F.R. Part 101.\*\*\*

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\* The Judge refused to enjoin sections of the statute limiting pre-operative hospital care to one day and post-operative care to twenty days on the grounds that, as implemented by the State's regulations, the limitations were being enforced in a manner which would cause no irreparable injury. (JA. 10-12.) Of the \$65 million annual cost savings which the State now says it is prevented from enjoying by reason of Judge Pratt's decision, \$45 million are in fact attributable to the hospital stay provisions which were not enjoined. (JA. 332.)

\*\* A New York Times article of January 20, 1977, p. 28, col. 5, quoted a spokesman for the Department of Social Services as stating that the financial impact of Judge Pratt's injunction on the State "would be about \$5 million a year."

\*\*\* Ironically one of the State's affidavits seeking to justify Chapter 76 lists eight categories of unnecessary

[Footnote continued on next page]



The same logical gap exists in another affidavit presented by the State setting forth statistics purporting to show that 15% of elective surgery has been determined to be medically unnecessary by the requirement of a second opinion as a prerequisite to coverage under private medical insurance programs. (JA. 269-72.) Whatever relevance this affidavit might have had -- given the fact that Chapter 76 goes far beyond the elimination of medically unnecessary surgery, denying Medicaid coverage for even medically necessary surgery where it can be deferred for six months without causing "severe pain," or threatening life or "essential function" -- its significance was seriously undercut by its failure to take into

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[Footnote continued from previous page]

surgery which were determined to be ineligible for Medicaid reimbursement by operation of the Hospital Utilization Review Program. (JA. 240-250.) Elsewhere the same affidavit states:

"The New York State Hospital Utilization Review Program ("NYSHUR"), a medical review of hospital utilization data, was announced November 5, 1973 and implemented January - March, 1974. Before any follow-up actions of any kind, there was a notable acceleration of discharges of long-stay patients from 12 hospitals in one region of the state, the first region in which the system was implemented." (JA. 254-255.)

Indeed, the duplicative operation of Chapter 76 and the PSRO program required defendant Commissioner of Social Services to provide for a means of resolving conflictive determinations with respect to medical eligibility under the two programs. (JA. 88, 90.)



account the facts that under New York's Hospital Utilization Review and PSRO programs, second opinions with regard to the medical necessity for hospital admissions are already mandated.

Further, the State contested as a factual matter the conclusions of plaintiff doctors and of the doctors of plaintiff patients that their patients' medical condition was not such as to deny them coverage under Medicaid. Without examination of plaintiff Doe, the State's witnesses including one non-medical witness opined that, contrary to the opinion of her own doctor (JA. 212, 220), her condition warranted surgery to rule out the possibility of a life-threatening condition (JA. 244, 334-36). With respect to plaintiff Ortega, the State's witnesses stated that as they interpreted the provision of Chapter 76 permitting surgery if it cannot be deferred for six months without interfering with an essential function, the statute would permit Medicaid coverage for Ortega if it interfered with his "employability" (JA. 335) or, as the State puts it on this appeal, "the patient's ability to function adequately in our society." (Brief at p. 27).

Finally, the State's witnesses attacked the plaintiff's failure to exhaust administrative remedies allegedly available to them. As noted below at pp. 41-44 of this Brief no such remedies exist for review of a determination by a patient's personal physician that the patient's medical



condition is not covered by Medicaid under State law, and it is with regard to that initial determination that this lawsuit is concerned.

#### POINT I

The District Court had jurisdiction over  
the subject matter of this litigation

Addressing only one of the numerous grounds on which plaintiffs demonstrated the District Court's jurisdiction over the subject matter of this dispute, the State asks this Court to find that the District Court lacked jurisdiction, based on the Supreme Court's reversal, a month after the Court's opinion in this litigation, of a case cited by the District Court in its opinion. Roe v. Ingraham, 403 F.Supp. 931 (Three Judge Court S.D.N.Y. 1975) rev'd. sub. nom., Whalen v. Roe, 45 U.S.L.W. 4166 (February 22, 1977). The grounds on which the Supreme Court reversed the cited case in no way undercut the grounds on which the District Court found jurisdiction to exist in this case and, in any event, there were ample alternative grounds on which jurisdiction existed in the District Court.

1. Jurisdiction under Section 1343. The District Court found jurisdiction on the basis of 28 U.S.C. §1343 and principles of pendent jurisdiction. (JA. 22.) In so finding the Court followed substantial authority holding, in other suits attacking state laws for conflict with



the Federal Social Security laws and on other constitutional grounds, that where the other constitutional grounds are not insubstantial, the Federal courts may consider the conflict between State and Federal law under principles of pendent jurisdiction, without having to consider whether the \$10,000 jurisdictional amount requirement of 28 U.S.C. §1331 is met or whether the conflict between State and Federal law itself presents a constitutional claim under the Supremacy Clause cognizable under 28 U.S.C. §1343 and 42 U.S.C. §1983 without regard for the amount in controversy. Hagans v. Lavine, 415 U.S. 528, 536 (1974); Rosado v. Wyman, 397 U.S. 397, 402-405 (1970); New York Dep't. of Social Services v. Dublino, 413 U.S. 405, 412 n. 11 (1973); Dandridge v. Williams, 397 U.S. 471 (1970); King v. Smith, 392 U.S. 309 (1968); Williams v. Wohlgemuth, 540 F.2d. 163 (3rd Cir. 1976); White v. Beal, 413 F.Supp. 1141 (E.D. Pa. 1976); Smith v. Towell, 379 F. Supp. 139 (W.D. Tex. 1974), aff'd, 504 F.2d 759 (5th Cir. 1974).

Of the several substantial constitutional claims presented by plaintiffs to the District Court, the only one which the Court found it necessary to consider, for the purposes of determining jurisdiction, was the allegation that the review of the medical condition of patients requiring surgery (not exempted by defendant Commissioner of Health on the basis of "medically indicated risk factors" and which in the opinion



of their own doctors cannot be deferred for six months without threatening life or "essential function" or causing "severe pain,") by persons, including non-physicians, other than their own doctors, violates the patients' constitutional right to privacy protected by the First Amendment. In the State's view the District Court's determination that this constitutional claim was not insubstantial was erroneous (1) because the decision in Roe v. Ingraham, supra, based on a three-judge court opinion in which the District Judge in this case found "support" for plaintiffs' position, was reversed by the Supreme Court a month subsequent to the decision under review in this proceeding, (2) because "under the circumstances" there will be minimal interference with the patients' privacy rights, and (3) because in the State's view the constitutional right of privacy is limited to "relationships which involve the most intimate phases of personal life having to do with sexual intercourse," citing Rosenberg v. Martin, 478 F.2d 520 (2d Cir. 1973). Brief at pp. 13-15. The State's arguments should be rejected by this Court if only because the State has not succeeded in demonstrating the "constitutional insubstantiality" of plaintiffs' claims as that phrase has been defined in applicable Supreme Court decisions. Roe v. Whalen, supra, in no way undercut and, indeed, reaffirmed the reasoning of that portion of the opinion of the three judge court in which Judge



Pratt found support for his conclusion. No evidence was introduced below with respect to the extent of interference with the patients' rights of privacy, and the constitutional right of privacy has not been limited to sexual intercourse as the State contends.

With regard to the standards for determining whether a constitutional argument is insubstantial or frivolous, the Supreme Court has articulated them in the following fashion in one of the cases cited by the State in support of their argument, in a portion of the opinion in that case, Gcosby v. Osser, 409 U.S. 512, 518 (1973) quoted and reaffirmed in Hagans v. Lavine, supra, 415 U.S. at 537-38 with respect to 28 U.S.C. §1343(3):

"'Constitutional insubstantiality' for this purpose has been equated with such concepts as 'essentially fictitious,' Bailey v. Patterson, 369 U.S., at 33; 'wholly insubstantial,' ibid.; 'obviously frivolous,' Hannis Distilling Co. v. Baltimore, 216 U.S. 285, 288 (1910); and 'obviously without merit,' Ex parte Poresky, 290 U.S. 30, 32 (1933). The limiting words 'wholly' and 'obviously' have cogent legal significance. In the context of the effect of prior decisions upon the substantiality of constitutional claims, those words impart that claims are constitutionally insubstantial only if the prior decisions inescapably render the claims frivolous; previous decisions that merely render claims of doubtful or questionable merit do not render them insubstantial for the purposes of 28 U.S.C. §2881. A claim is insubstantial only if 'its unsoundness so clearly results from the previous decisions of this court as to foreclose the subject and leave no room for the inference that the questions sought to be raised can be the subject of controversy.' Ex



parte Poresky, supra, at 32, quoting from Hannis Distilling Co. v. Baltimore, supra, at 288; see also Levering & Garrigues Co. v. Morrin, 289 U.S. 103, 105-106 (1933); McGilvra v. Ross, 215 U.S. 70, 80 (1909)." (Emphasis supplied.)

Here, as discussed infra, defendants cite to this Court no "prior decisions" of any court rendering plaintiffs claims even "of doubtful or questionable merit," much less what Hagans requires, namely previous decisions of the Supreme Court which "foreclose the subject and leave no room for the inference that the questions sought to be raised can be the subject of controversy." Clearly plaintiffs' constitutional claims cannot be found insubstantial under this standard.

The only decision of the Supreme Court presented by the State as "foreclosing the subject" is the reversal of Roe v. Ingraham sub. nom., Whalen v. Roe, supra, which leaves ample room for the inference that the questions at issue can be the subject of controversy and is, in any event, not "previous" to the decision of the District Court in this case. Whalen v. Roe, supra, did not involve as does this case the medical examination of a patient by a second doctor not of the patient's own choosing and the review of the patients' medical condition by physicians and non-physicians, but rather New York State's computerized record-keeping system of prescription forms for narcotic drugs. In a portion of the decision not quoted by the State, the Supreme Court expressly distinguished



the case before it from its own prior precedents in which the constitutional right of privacy had been recognized in situations in which a state has required, as New York does here, the written concurrence of physicians "other than the patient's personal physician," 45 U.S.L.W. at 4169, n. 31. Clearly the Supreme Court in Whalen v. Roe did not "foreclose," but left open the issue presented by this case.

The State introduced no evidence below with regard to its efforts, if any, to assure that the invasion of the patients' privacy rights in connection with obtaining second opinions and reviewing the conclusions of a patient's personal physician will be "minimal". In this Court the State relies solely on provisions of Federal Medicaid law and regulations directing a State as part of its Medicaid program to develop "safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the [state's] plan," 42 U.S.C. §1396a(a)(7), 45 C.F.R. §205.50. The State then points to provisions of the New York Civil Practice Law and Rules, ("CPLR") §4504, and of the New York Education Law §6527(3), to demonstrate the State's compliance with the Federal directive. If these statutory provisions are all the State has done to minimize interference with a patient's constitutional right of privacy, the State has done very little indeed. The cited



provision of the CPLR does no more than restrict doctors from disclosing confidential communications in civil judicial proceedings in courts of the State of New York. CPLR §§4504 and 101. Section 6527(3) of the New York Education Law on its face (1) requires the maintenance of confidentiality only by doctors and not by the non-physicians who are part of the State's scheme of review; (2) applies solely to doctors serving on hospitalization review committees established under 42 U.S.C. §1395x(k), a system of review which duplicates, but is entirely distinct from the review system and second opinion requirement imposed by Section 365-a; and in any event (3) in no sense places limitations on the disclosures which are required to be made by patients to the reviewing doctors and non-doctors in order to obtain Medicaid coverage for their surgery.

Finally, the State's argument that the constitutional right of privacy has been limited to "the most intimate phases of personal life having to do with sexual intercourse" (Brief at p. 15) is based upon arrant misquotation from the decision in the case relied upon by the State for this proposition. What this Court said in Rosenberg v. Martin, 478 F.2d 520, 524-525 (2d Cir. 1973) was that the right recognized in that case involved not "the most intimate phases of life having to do with sexual intercourse" (Brief at p. 15), but rather "the



most intimate phases of personal life." In all events the examination of plaintiff Roe's reproductive organs or those of patients suffering from lipoma of the vulva, and venereal warts to determine the accuracy of their own gynecologist's findings with respect to their need for surgery involves a cognizable right of privacy under either standard. Further, the examination of patients suffering from bleeding hemorrhoids and cystocoele or dropping of the bladder clearly meets the requirements articulated in Rosenberg v. Martin, supra, correctly stated.

2. Additional substantial constitutional questions.

Other substantial constitutional questions exist in this case conferring jurisdiction on the District Court. Section 365-a(5)(b) permits the Commissioner of Health to exempt from the limitations of the Section, certain surgical procedures "on the basis of medically indicated risk factors" without indication of the nature of the "medical risk" referred to in the context of a statute which refers elsewhere to many different types of risk including "the medical risk associated with... surgical intervention" (which affords a second and separate ground for exemption), risks of death and interference with "essential function" and the risk of "severe pain." The Commissioner of Health has exercised his discretion under this provision to exempt five types of surgical procedure, including



among them voluntary abortions and vasectomies, despite the fact that, as all doctors testified below, there exists no difference in terms of "medically indicated risk factors" under any interpretation of that phrase which justifies a distinction between voluntary abortions and vasectomies, on the one hand, and other surgical procedures not exempted, on the other. (JA. 51, 53, 186, 223.)\*

Clearly the ambiguous use of the phrase "medically indicated risk factors" in the statute and the Commissioner of Health's arbitrary interpretation of it raise substantial constitutional questions on the due process grounds. In Hynes v. Mayor of Oradell, 425 U.S. 610 (1976), decided this last term, the Supreme Court struck down a municipal ordinance which erred, like the statute at issue here, in failing to spell out the type of factors to be considered by the executive agency applying the statute:

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\* Whatever the wisdom of the decision to exempt vasectomies and voluntary abortions from the limitations of Section 365-a from a political standpoint or as a matter of litigation strategy, the decision illustrates the total absence of standards contained in the phrase, "medically indicated risk factors." On the face of it, it is totally arbitrary and incomprehensible to say that "medically indicated risk factors" require coverage for voluntary abortions and vasectomies but not for surgery to alleviate the conditions referred to in the complaint and affidavits of Drs. Koff and Rosenberg. (JA. 51-52, 186-187.) If "medically indicated risk factors" is broad enough to encompass the risks of constitutional challenge in the courts, the phrase is obviously too broad to be sustained on due process grounds.



"First, the coverage of the ordinance is unclear; it does not explain, for example, whether a 'recognized charitable cause' means one recognized by the Internal Revenue Service as tax exempt, one recognized by some community agency, or one approved by some municipal official...Nor does the ordinance 'provide explicit standards for those who apply' it." [citing Grayned v. City of Rockford, 408 U.S. 104, 108 (1972) relied on by defendants herein] Hynes v. Mayor of Oradell, supra, 425 U.S. at 621.

Similarly, Chapter 76 in failing to specify the type of medical risks referred to does not "provide explicit standards for those who apply it."

In addition Section 365-a(5)(c) makes the availability of Medicaid coverage turn on a determination by a patient's physician as to whether deferral of the surgery for six months will cause "severe" as opposed to some other degree of pain, or interfere with an "essential function." As the testimony of the doctors below makes clear, the phrase "severe pain" has no accepted medical meaning and is so subjective as to be incapable of meaningful review. (JA. 50, 185-186, 208-209.) The interpretation of the term "essential function" by the State to refer to "the patient's ability to function adequately in our society" (Brief at p. 27) renders it "so vague and indefinite as to be no rule or standard at all." Small Company v. American Sugar Refining Company, 267 U.S. 233, 239 (1925). As Justice Frankfurter noted in Joseph Burstyn, Inc. v. Wilson, 343 U.S. 495, 532 (1952) where the initial decision:



\*\*\*\*is rested, in the first instance, in an administrative agency, the available judicial review is in effect rendered inoperative. On the basis of such a portmanteau word as 'sacrilegious,' the judiciary has no standards with which to judge the validity of administrative action which necessarily involves, at least in large measure, subjective determinations. Thus, the administrative first step becomes the last step."

With respect to the "severe pain" standard, the patient is given no objective criteria or administrative route by which to contest an adverse determination on his claim that his pain is "severe," while doctors are entirely at the mercy of a reviewing body making determinations according to standards which are for both the doctor and the reviewer essentially unknowable. In the language of Justice Frankfurter in Joseph Burstyn, Inc. v. Wilson, supra, 343 U.S. at 533, the availability of public assistance is made to turn on "things in the mind, and things in the mind so undefined, so at large, as to be...patently in disregard of the requirement for definiteness,...".

The State's regulations, far from giving specific substance to the phrase "severe pain," in fact do nothing but repeat the phrase. 10 NYCRR §85.3(a). Moreover, the affidavit of one doctor for the State which seeks to equate the "significant discomfort" of hemorrhoids with "severe pain," (JA. 259) merely illustrates the confusion which the standard creates both for those who apply it and for those to whom it applies.



The interpretations which defendants in their answering papers placed on the expression "essential function," as noted above, far from giving specific substance to the phrase, render it meaningless. (JA. 50, 208). Moreover, the best intentions of the Department of Health and the Department of Social Services in applying the law broadly cannot save a statute which is to be read and followed in the first instance by the doctors and Medicaid patients of the State. "Well-intentioned prosecutors and judicial safeguards do not neutralize the vice of a vague law." Baggett v. Bullitt, 377 U.S. 360, 373 (1964). Or, as was said in Keyishian v. Board of Regents, 385 U.S. 589, 599 (1967):

"It is no answer to say that the statute would not be applied in such a case. We cannot gainsay the potential effect of this obscure wording on 'those with a conscientious and scrupulous regard for such undertakings.'"

And see, Fairbanks v. United States, 181 U.S. 283, 311 (1901).

The Supreme Court has set forth the test for vagueness:

"[A] statute which...requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the trust essential of due process of law." Connally v. General Construction Co., 269 U.S. 385, 391 (1925).

And see Lanzetta v. New Jersey, 306 U.S. 451, 453 (1938).

Here anyone must necessarily guess at the meaning of the phrases "medically indicated risk factors" and "essential function," interpreted to mean the patient's ability to



function adequately in our society; and nothing in common intelligence will aid one in assessing whether another man's pain is "severe."

Further, the exclusion of certain types of deferrable surgery from the limitations of Chapter 76 based on "medically indicated risk factors" and the attempt to draw the line between reimburseable and non-reimburseable surgery on the basis of the severity of the patient's pain both violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. Where a state statute creates classifications based on differences irrelevant to the achievement of the state's objectives, the classifications will be struck down under the Equal Protection Clause. Hagans v. Lavine, 415 U.S. 528 (1974); Dandridge v. Williams, 397 U.S. 471 (1970); James v. Valtierra, 402 U.S. 137 (1971); Richardson v. Belcher, 404 U.S. 78 (1971); Jefferson v. Hackney, 406 U.S. 535 (1972).

The lack of rationality of the distinctions drawn in the law and implementing regulations between those surgical procedures which require second opinions and those which do not is nowhere more clear than in the elimination of voluntary abortions and vasectomies from the category of procedures requiring a second opinion to the effect that the procedure may not be deferred without threat to life or essential function or causing severe pain. Neither in terms of patient health or



in terms of the State's fiscal problems can there be found justification for permitting Medicaid coverage of those procedures while eliminating coverage for others.\*

Nor can a distinction between a patient saying he has "moderate pain" and a patient who says he has "severe pain," denying the former Medicaid coverage while affording it to the latter, be justified in terms of the statute's purposes. The patient's, particularly the low income and indigent patient's, ability to articulate his subjective feelings has nothing to do with his health, while the degree of his pain has nothing to do with the cost of surgery to relieve it.

Here the purposes of Chapter 76, as set forth in the statute, are to conserve the state's monetary resources, in light of its fiscal crisis, in a manner that will "assure that funds are available for essential and critical medical services, that basic medical necessities for the needy are provided, and that critical assistance, care and health services will be available to all of the people...". Ch. 76, Laws of New York, 1976, §1. Since the types of deferrable surgery permitted under the "medically indicated risk factors" standard of

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\* To be sure, a statute which had as its purpose population control, if such a statute could ever be passed in New York, might support Medicaid coverage for vasectomies and voluntary abortions. This statute certainly has no such purpose.



Chapter 76 are indistinguishable in terms of medical necessity and in terms of cost from other deferrable surgery for which reimbursement is prohibited, neither the objective of cost-saving nor the furnishing of medical necessities to the needy are served by the classification. Nor are these objectives served by a distinction in terms of the patient's subjective pain since the degree of pain says nothing about the cost of the surgical procedures necessary to deal with the patient's condition. The subjectivity of the standard means inevitably that patients who are from an objective medical standpoint suffering from identical medical ailments will receive different treatment under the statute.

The imprecision of the classifications drawn by the statute guarantees the kind of arbitrary and capricious enforcement which the equal protection clause forbids. Persons similarly situated may not receive disparate treatment by the state when that difference is without any rational basis.

Davis v. Georgia State Bd. of Ed., 408 F.2d 1014 (5th Cir. 1969). Here, where distinctions will be drawn by the subjective perceptions of those involved, the effect of any attempt at enforcement will be discriminatory. Many of those who are denied benefits may in fact be suffering more severe pain than those who receive benefits. Even though the discriminatory effect may not have been intended, the equal



protection clause forbids any government action which has such an arbitrary impact, Norwalk CORE v. Norwalk Redevelopment Agency, 395 F.2d 920 (2d Cir. 1968), Levy v. Parker, 346 F.Supp. 897 (E.D. La. 1972), aff'd 411 U.S. 978 (1973). The means employed by the state to create classes must be precisely drawn in light of the state's purposes. Sugarman v. Dougall, 413 U.S. 634 (1973).

In any event, the issue for this Court at this time is the substantiality of the constitutional issues presented. What was said on this particular issue in Hagans v. Lavine, supra, 415 U.S. at 539 is applicable here:

"...we cannot say that the equal protection issue tendered by the complaint was either frivolous or so insubstantial as to be beyond the jurisdiction of the District Court. We are unaware of any cases in this Court specifically dealing with this or any similar regulation and settling the matter one way or the other." (Emphasis supplied).

Defendants have cited no case to this Court specifically dealing with this or any similar regulation and settling the matter one way of the other.\*

3. Jurisdiction under Section 1331. Even had plaintiffs' constitutional claims been less substantial than

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\* In addition to their substantial due process, equal protection and privacy claims, plaintiffs presented a substantial constitutional question under the Supremacy Clause cognizable under 28 U.S.C. §1343 and 42 U.S.C. §1983 without regard for the amount in controversy. Cf. Hagans v. Lavine, supra, 415 U.S. at 533, N. 5



they are, the District Court had jurisdiction, since plaintiffs' claim that Section 365-a conflicts with the Federal Medicaid statute clearly arises under the Constitution and Laws of the United States within the meaning of 28 U.S.C. §1331(a) and no evidence was introduced below disputing plaintiffs' position that the matter in controversy exceeds \$10,000 exclusive of interest and costs.

Nor are defendants in any position to contest the \$10,000 allegation in view of their own averments concerning the high costs of surgery and associated hospital care. As the Second Circuit has said: "absolute certainty in valuation of the right involved is not required to meet the amount in controversy requirement...." On the contrary, "courts should dismiss only when it is clear to a legal certainty that jurisdictional amount cannot be met." Moore v. Betit, 511 F.2d 1004, 1006 (2d Cir. 1975); see also, St. Paul Mercury Indemnity Co. v. Red Cab Co., 303 U.S. 283, 288 (1938).

In applying this principle, courts have refused to underestimate the value of injuries to constitutional rights of the plaintiff. Thus, in Spock v. David, 469 F.2d 1047 (3d Cir. 1972), the court found itself unable to determine "to a legal certainty" that plaintiffs would be unable to substantiate their allegation that a \$10,000 injury resulted from defendants' action barring them from conducting their political



campaign at a military reservation. And see Opelika Nursing Home, Inc. v. Richardson, 448 F.2d 658 (5th Cir. 1971) on remand 356 F.Supp. 1338 (M.D. Ala. 1973).

Here plaintiff physicians are not only prevented from engaging in a long list of surgical procedures under circumstances in which they would ordinarily perform them, but also a single improper decision on the part of one physician plaintiff by reason of the Statute's vagueness could damage his professional reputation, jeopardize his right to services performed and expose him to malpractice litigation of a value clearly in excess of the jurisdictional minimum. Since each plaintiff physician would be exposed to such injury with regard to each determination on coverability made by him, the threatened jury must be multiplied by the numerous surgical decisions made each year by each physician plaintiff. With respect to plaintiff patients, it is plain that the value of their health and well-being which is at stake in this litigation exceeds the jurisdiction limit. See Stanton v. Bond., 504 F.2d 1246, 1251 n. 25 (7th Cir. 1974), cert. denied, 420 U.S. 984 (1975).

## POINT II

### Plaintiffs have standing

The State argues that the plaintiff patients lack standing because they have failed to exhaust administrative



remedies allegedly available to them and that plaintiff doctors and The Medical Society of the State of New York lack standing to litigate the availability of payment for needed surgery for indigent patients because, according to the State, only the indigent patients are "proper proponents" of the rights on which this suit is based. Singleton v. Wulff, 428 U.S. 106, 112 (1976). The answer to the State's first argument is that there exist, under the statute and regulations at issue in this litigation, no administrative remedies for the patient plaintiffs to exhaust. The answer to the State's second argument is that the factual arguments concerning the impropriety of having the plaintiff doctors in this case represent the interests of their patients were resolved against the State by the District Judge below, acting well within his discretion, on the basis of the factual record submitted to him on this issue.

1. Standing of Plaintiff Patients. The State statute and regulations at issue in this litigation require as a prerequisite, not simply for obtaining Medicaid coverage, but also for obtaining an administrative ruling from the State with regard to coverability, findings in the patient's own proposing physician that deferral of surgery for six months may jeopardize life or essential function or cause severe pain. Social Services Law §365-a(5)(c); 10 NYCRR §85.3(b). Under the State's regulations the patient may not even "request" a determination as to coverage from the State or an examination



necessary to obtain coverage; such a "request" can come only from the patient's "proposing surgeon" together with his findings, based on his examination, that deferral for six months will threaten life or an essential function or cause severe pain.

In this connection the regulations issued by defendant Commissioner of Health pursuant to the statute provide:

"A determination of coverability shall be based on the likelihood that deferral of the proposed surgery for six months or more may jeopardize life or essential function, or cause severe pain.

"The required determination of coverability shall be initiated by written request from the proposing surgeon, with information adequate for making the determination." (Emphasis supplied.) 10 NYCRR §85.3

Appellate administrative remedies with regard to an adverse determination by the Department of Health are again expressly limited to remedies for the proposing physician and not for the patient. In this regard, 10 NYCRR §85.3(g) provides:

"The proposing surgeon may appeal any determination of non-coverability to a physician or physicians designated by the Commissioner of Health for such purpose." (Emphasis supplied.)

Here plaintiff patients' physicians, their proposing physicians, could not even initiate a request for a determination of coverability and could not supply the information necessary to support a determination of coverability, because, based on their examination of their patients, they were unable



to make the findings that deferral for six months would threaten life or an essential function or cause severe pain. Nothing in the State statute or regulations permits a patient in these circumstances to obtain an examination by a State doctor or to seek review of his or her own proposing physicians' negative determination on coverability; if that negative determination were confirmed by the State, the patient is denied appellate review.\*

Thus the cases of the plaintiff patients are clearly ripe for review since they have already been injured by the State's statute and regulations. Their doctors, who must interpret the statute and regulations in the first instance, have done so and made a determination which adversely affects their patients' rights. The statute is designed in the first instance to control the conduct of the patients' doctors. It has done that to the patient's injury, and their cases are ripe for review.

In any event, exhaustion of State administrative remedies is today simply not a tenable ground for avoiding litigation premised on the unconstitutionality of the law and

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\* No provision is made in the statute for examination of the patient or development of additional information by the State concerning the patient in making a determination of coverability unless a second opinion is required. 10 NYCRR §85.3. Thus, the entire administrative scheme depends in the first instance on the examination by the proposing physician, and if the proposing physician cannot make the requisite findings, the patient has no remedy except in a court of law.



regulations here under attack. King v. Smith, 392 U.S. 309, 312 n. 4 (1968); McNeese v. Board of Education, 373 U.S. 668 (1963); Monroe v. Pape, 365 U.S. 167, 180-83 (1961); Eisen v. Eastman, 421 F.2d 560, 567-69 (2d Cir. 1969), cert. denied, 400 U.S. 841 (1970).

2. Standing of Plaintiff Doctors. The District Court found standing in plaintiff doctors not simply to litigate their own claims concerning the invalidity of Chapter 76, but also to litigate the claims of those of their patients who desire medically necessary surgery but cannot obtain it as a result of the limitations contained in the State statute.\* The State does not question the standing of the doctors to litigate their own claims concerning the statute's invalidity at least so far as they themselves perform surgery and, thus, have an obvious pecuniary interest in the statute's application (Brief at p. 16).\*\* However, the State questions, on a

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\* The State appears to argue, gratuitously, that plaintiff doctors should not have standing to litigate claims on behalf of patients who do not desire surgery or who desire surgery which is not medically necessary. Brief at pp. 18-19. However, plaintiff doctors do not purport to represent their patients in such circumstances, but only patients desiring surgery under circumstances such as those outlined in the complaint in which the surgery is clearly medically necessary, albeit deferrable within the meaning of the State statute.

\*\* Having conceded the standing of plaintiff doctors to litigate their own claims that Chapter 76 is invalid, inter alia, because it restricts the availability of compensation under Medicaid in a fashion which conflicts with Federal law, the State argues in brief and conclusory fashion that the rights to payment for "physicians' services furnished by a physician" guaranteed by Federal

[Footnote Continued on Next Page]



factual basis, whether the doctors are appropriate representatives of the patients since:

"It is not clear that their physicians have any desire to provide those operations since they never attempted to ascertain whether the State would pay for them." (Brief at p. 18.)

It is clear from this statement of its position that the State's argument is merely another form of its argument on exhaustion of administrative remedies discussed in subdivision (1) of this Point, supra. The answer to it is the same: there exists no administrative remedies for either the patient or his or her physician to exhaust. If the doctor cannot make the factual findings required as a prerequisite to initiating a State determination of coverability, there is no way in which either the doctor or the patient can obtain such findings from the State.

In any event, it bears noting that the very fact that plaintiff doctors have commenced this litigation and the pecuniary stake (which the State concedes) of the doctors in obtaining Medicaid coverage belies the State's claim that the plaintiff doctors do not desire to provide the operations their

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law 42 U.S.C. §1396a(a)(13)(B) were solely rights of the patients and not rights of the doctors. Brief at p. 20. The State's position is not only internally inconsistent, but contrary to the authorities cited by the State in recognizing the standing of the doctors. Singleton v. Wulff, 428 U.S. 106 (1976); National Union of Hospital Care Employees v. Carey, Docket No. 76-7203, Slip op. at 2411 (2d Cir. March 18, 1977).



patients need. Where, as here, the patient's rights are "inextricably bound up in the activity which the litigant [doctor] wishes to pursue" and where, as here, there exists, as the District Court recognized, numerous limitations on the ability of the indigent patients to assert their own rights (including the very fact of their indigency, the difficulty of their joining together to assert their rights, and the continuing possibility that, as a result of deterioration in their physical condition, their claims will become moot\*), the District Court was entirely within its authority in recognizing standing in the doctors to litigate their patients' claims. Singleton v. Wulff, supra, 428 U.S. at 117. In all events, all that is necessary at this juncture is for the Court to find standing in one of the patient plaintiffs to assert the claims on which the preliminary injunction issued. As discussed above, such standing clearly exists since the State's exhaustion argument is without merit.

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\* The imminent mootness of the claims of plaintiff patients is a very real consideration in this case since in the case of both plaintiff Doe and Ortega the predicted worsening of their condition will entitle them to surgery under the urgent or emergency surgery standards. Plaintiff Doe, indeed, has already obtained surgery because her continued abnormal menstrual bleeding permitted her doctor to make findings necessary to obtain surgery on an emergency basis. Once plaintiff Ortega's situation deteriorates sufficiently to permit a finding that continued postponement of surgery on him will impair his vision, he too will be able to obtain surgery without regard for the statute's limitations.



### POINT III

The District Court properly found that the  
State Statute conflicts with Federal law.

The State argues that the District Judge abused his discretion in concluding that plaintiffs were likely to prevail on the merits. The basis for the State's argument is (1) that a state is entitled under Federal Medicaid Law to limit the hospital services and physician's services provided under a state Medicaid program to eliminate surgery that is medically unnecessary and to insure that high quality medical care is provided and (2) that, by virtue of what it calls the "catchall" provision in Social Services Law 365-a(5)(c) permitting surgery which cannot be deferred for six months without threatening an "essential function," only medically unnecessary and low quality surgery will be eliminated by the statute. Brief at pp. 22-30. The argument will not withstand scrutiny.

What bears noting first of all is that, contrary to the State's argument (Brief at p. 24), the District Judge explicitly accepted the State's contention that Federal Medicaid Law permits a state to eliminate medical care which is medically unnecessary and of low quality.\* JA. 29-30. There

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\* 45 C.F.R. §249.10(a)(5)(i) provides:

"Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures."

[Footnote continued]



can thus be no claim that the District Judge abused his discretion by ignoring what the State claims is applicable law.\*

The District Court did, however, reject the State's argument, repeated in this Court, that "a medically necessary surgical procedure is one in which, under the circumstances of the specific case, a failure to perform the surgery may result in a curtailment of the patient's ability to function adequately in our society." Brief at p. 27; JA. 30. Clearly, the

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The basis for this regulation and for construing its meaning is to be found in the preamble to Title XIX, 42 U.S.C. §1396, which states that Medicaid is established:

"[f]or the purpose of enabling each State...to furnish (1) medical assistance on behalf of families with dependent children...whose income and resources are insufficient to meet the costs of necessary medical services,...". (Emphasis supplied.)

As some Courts have said, these provisions authorize a state to deny Medicaid coverage where there is no medical need for health care services at all, e.g. tattoo removal, hair transplants, etc.; however, the same cases hold that a state may not choose, under the cited provisions, between more necessary and less necessary medical services, providing payment for one but not for the other. See Doe v. Beal, 523 F.2d 611 (3rd Cir. 1975) and the cases therein cited.

\* While the State quotes language from District of Columbia Podiatry Society v. District of Columbia, 407 F.Supp. 1259, 1264 (D.D.C. 1975) in an apparent effort to suggest that a state may eliminate even medically necessary services in the interests of economy, that case in fact dealt with podiatrist services, which unlike the physicians' services at issue here are not mandatory services under the Federal Medicaid program and which the District Court in that case found could be the subject of an economy measure by the local government precisely because they were not considered a medical necessity by Congress. 407 F.Supp. at 1265-66.



Court was right in so ruling since the State's quoted criterion, (even assuming it to be a proper gloss on the statute's reference to a patient's "essential functions") defines the term "essential function" not in terms of any medical need, but rather in terms of what is essential or necessary in terms of an individual's role in society.\* Clearly what the State is arguing is that it has authority to limit the availability of medical care which is not necessary in terms of society's needs as interpreted by the State Departments of Health and Social Welfare. The District Judge's rejection of the argument is supported not only by the language of the Federal statute, which speaks in terms of medical rather than social needs, but also by the case law. White v. Beal, 413 F. Supp. 1141 (E.D. Pa. 1976).

In White v. Beal, supra, the Court was faced with an argument by the State of Pennsylvania that the State was authorized to deny Medicaid coverage for prescriptions for eyeglasses, except where eyeglasses were required to treat eye disease or pathologic condition, by a Federal regulation, 45

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\* That the State is quite serious in its strained interpretation of what it calls the "essential function" catchall of Social Services Law §365-a(5)(c) is made apparent from its contention that surgery is medically necessary for plaintiff Ortega if it will permit him to work (JA. 335), but not presumably if it will only permit him, as a seventeen year old, to play. So too, a woman suffering from a lipoma may have it removed if it will help sexual procreation, but not if she is too old, in the State's opinion, to engage in sexual intercourse (Brief at p. 27).



C.F.R. §249.10(a)(5)(i), which states that Medicaid coverage for such items need only "be sufficient in amount, duration and scope to reasonably achieve their purpose." The State argued that "their purpose" in the Federal regulation referred to the purposes of the State of Pennsylvania, which, like New York in this case, found its purposes best served by excluding Medicaid coverage. The Court rejected this argument in the following language:

"As the first criteria, the state argues that 'their purposes' refer to the state's purposes. The argument is so utterly devoid of merit that it warrants no discussion. It is virtually unthinkable that the Secretary of Health, Education and Welfare would give the state virtually unbridled discretion in the form of such a 'loophole.' The plain meaning is that 'their' refers to the items of service. Thus, in providing eyeglasses, a state must provide the scope of service sufficient to achieve the purpose of the item in the scheme of the federal program. Cf., Doe v. Beal [523 F.2d 611] at 621. As the definition makes clear, the purpose of eyeglasses is to aid or improve vision, not merely to deal with eye disease or pathology." 413 F. Supp. at 1153.

Just as clearly, "necessity", in the phrase "medical necessity", refers to the patient's medical needs, not society's; to allow New York State to define medical necessity in terms of what it thinks it needs to have a patient "function adequately in our society" would be to create a loophole in Federal law in the name of which most of the State's Medicaid program could be abandoned.\*

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\* The State dismisses the letters from the Regional Director of the Department of Health, Education and Welfare, disagreeing with its conclusion that Chapter 76 conflicts

[Footnote continued]



#### POINT IV

The District Court did not abuse its discretion in its determination as to where the public interest lies in this case.

The State argues that the District Judge abused his discretion in its determination with regard to the balancing of hardships in this case, or "made a clear mistake of law" in making its determination (Brief at p. 34). What the District Court's mistake of law was the State's brief does not say, and the factual matters presented by the State to the District

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with Federal law, with a statement, without record support, that the letters are "preliminary." A comparable letter was relied on by the Court in White v. Beal, supra, 413 F. Supp. at 1153, fn.9. Moreover, the Governor of New York State has recognized, in his statement upon signing Chapter 76 into law (quoted at pp. 58-59, infra), that these letters represent the position of the Department of Health, Education and Welfare. Session Law News (McKinney, May 10, 1976) at A-251. This Court has recognized the weight attributable to HEW interpretations of its statutes in resolving conflicts of the type presented by this case. As this Court has recently recognized in another case involving an alleged conflict between State and Federal Medicaid law, McGraw v. Berger, 537 F.2d 719, 725-26 (2d Cir. 1976):

"We agree with the State and the District Court that when the agency entrusted with the execution of a federal statute has interpreted that statute, it is entitled to considerable deference. Red Lion Broadcasting Co. v. F.C.C., 395 U.S. 367, 381, 89 S.Ct. 1794, 23 L.Ed. 2d 371 (1969). The Supreme Court has applied this rule to HEW interpretations of the Social Security Act. New York Department of Social Services v. Dublino, 413 U.S. 405, 421, 93 S.Ct. 2507, 37 L.Ed. 2d 688 (1973)."



Court as bearing on the balancing of the hardships were taken into account by the District Judge in reaching his decision.\*

Thus, the District Court explicitly took into account "the serious financial impact that the order issued pursuant to this memorandum will have on the State of New York" as well as the State's argument that certain "unwarranted surgical procedures" might be eliminated by the State statute along with the numerous medically necessary procedures also struck down. (JA. 34-35.) However, acting clearly within his discretion, the District Judge found that these considerations were outweighed by the interest of indigent patients and their doctors in obtaining Medicaid coverage for surgery to relieve the

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\* The State raises for the first time on this appeal the spectre of "financial chaos" allegedly resulting from the preliminary injunction in this case. Brief at p. 33. It neither made that argument nor advanced facts to support it below where its position was simply that the issuance of the injunction would cost the State additional money. To be contrasted with the State's case below is Long v. Robinson, 432 F.2d 977 (4th Cir. 1970) in which the State proved on the record that funds were not available to comply with the Court's injunction and in which, nevertheless, the injunction granted was sustained on appeal. Had the State offered evidence below either that funds are not available to comply with the Court's order, or that they would have to be taken from other programs, cross-examination would have been appropriate with regard to the State's \$40 million reserve fund for unanticipated expenses (see New York Times, March 22, 1977, p. 38, col. 1), and with regard to the relative need for money for Medicaid as opposed to other of the State's programs.

variety of medical complaints barred from remedy by the State law.

The irreparable injury resulting from the enforcement of Section 365-a(5) is plain. Indigent patients whose pain is real and substantial but less than what the State decides to call "severe" and patients suffering from conditions which interfere with functions which the State decides are not "essential" will be, or in the case of plaintiff Ortega, have been denied the medical opinion necessary to obtain Medicaid coverage for their surgery. The patients have no administrative remedy for this situation since both the initiation and appeal of any determination of non-coverability by defendants' departments can only be accomplished by the patients' proposing surgeons under defendants' own regulations. 10 NYCRR §85.3(c) and (g). The patients are hence condemned to suffer from their conditions until they have sufficiently deteriorated to constitute a threat to their lives or to essential functions or cause them severe pain. At that time the surgery will have to be performed in any event and the State will, unless the patient's financial circumstances change, have to pay for the surgery, so that the State will not avoid the expense in many cases, of which plaintiff Ortega's is one example, but only defer it.



Drs. Koff and Rosenberg and the members of plaintiff Medical Society suffer immediate and irreparable harm from Chapter 76 because it is for them to apply in the first instance. They are the ones who are confronted every day with the task of interpreting this vague statute and determining whether their patients are eligible for medical assistance. If they determine that there is no coverage, their ability to provide their patients with medically necessary surgery is interfered with, their relation of trust and confidence with their patients is injured and their ability to practice the profession they are licensed to practice is curtailed. If they err in their determination because of the vagueness of the statute and because of defendants' unwillingness to abide by the statute's language, the plaintiff physicians are faced with the threat of malpractice litigation and professional sanction under the PSRO statute and Hospital Utilization Review program which prescribe sanctions for medically unnecessary hospital admissions. 42 U.S.C. §1320c, 42 C.F.R. Part 101; 42 U.S.C. §1395x(k), 10 NYCRR §721.2.

Moreover, doctors are not yet, like public utilities and common carriers, required to serve all comers. The chilling effect of Chapter 76 and defendants' regulations have already deterred many physicians from accepting any new Medicaid patients. (JA. 226). Here, both doctor and patients

suffer because the duplicative and burdensome requirements of an unnecessary law, badly administered, have had an in terrorem effect of persuading many doctors to leave the field entirely.\* Why should a doctor become the one who must initiate and carry the burden of an appeal with respect to a determination of non-coverability? And why should a doctor run the risk of malpractice litigation because he has not foreseen that "severe pain" will be equated with "significant discomfort" by the administering agency?

The "balance of hardships," Hamilton Watch v. Benrus Co., 206 F.2d 738 (2d Cir. 1953), tips decidedly in plaintiffs' favor when it is considered that not only will the state have to pay eventually for much surgery now deferred but that as defendants intend to apply the law simply to the elimination of unnecessary surgery, the statute is in all significant respects duplicative of the New York Hospital Utilization Review Program and the PSRO statute. With those programs still in effect, eliminating unnecessary surgery as defendants in their own papers demonstrate they are doing (JA. 254-255), the State will

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\* In Keyishian v. Board of Regents, 385 U.S. 589, 601 (1967) the court stated:

"The very intricacy of the plan and the uncertainty as to the scope of its proscriptions make it a highly efficient in terrorem mechanism."



suffer no revenue loss from the entry of the preliminary injunction in this case.

In all events, even where the threat to a state's revenues is greater than it is in this case, the courts have found that the health of the affected patients outweighs the State's interest in allocating its resources away from health care and into other areas. In Robinson v. Maher, \_\_\_ F.Supp. \_\_\_, 3 CCH Medicaid and Medicare ¶27,707 (D. Conn. Jan. 19, 1976) the District Court, after taking into account the fiscal crisis of the State of Connecticut, stated the rule applicable here:

"When considerable injury will result from either the grant or denial of a preliminary injunction, these factors to some extent cancel each other and greater significance must be placed upon the likelihood that each party will ultimately succeed on the merits of the litigation." Delaware River Port Authority v. Transamerican Trailer Transport, Inc., 501 F.2d 917, 924 (3rd Cir. 1974).

"Since the likelihood of success on the merits here is strongly in the plaintiffs' favor, a preliminary injunction will issue. This Court has the power to prohibit the State's use of Federal funds in a manner incompatible with Federal law, and can enjoin the State from such further use of Federal moneys, Rosado v. Wyman, 397 U.S. 397 (1970)."

In these circumstances the District Court's exercise of its discretion should not be disturbed. Brotherhood of Locomotive Engineers v. Missouri-Kansas-Texas R. Co., 363 U.S. 528, 535 (1960), United States v. Yellow Cab Co., 338 U.S. 338, 342 (1949).

A further factor entering into the District Court's determination suggests, moreover, that whatever injury the State now alleges it will suffer was brought upon itself by its delay in acting to avoid the litigation now before this Court by seeking remedies available from the State legislature.\* Thus in footnote 7 of the District Court's opinion (JA. 37-38), the Court took note of the following statement by the Governor of New York State upon signing Chapter 76 into law:

"This bill is a substantially amended version of my original Budget Bill submitted both in the Special Session last year and again early in this Session. It has been changed by the Legislature in virtually every major respect, and as a result, both the Commissioner of Health and the Acting Commissioner of Social Services have advised me that they have serious reservations about the bill. In addition, the Regional Director (Region II) of the Department of Health, Education and Welfare has written to express the Department's concern over certain provisions in the bill.

"The expenditure savings projected under the bill are essential to achieve a balanced budget, and because of the urgent need to present such a budget for the State of New York, I must sign this measure into

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\* Clearly, the State cannot complain of the issuance of a preliminary injunction on the ground it will cause it injury, however irreparable, which it has brought on itself. Long v. Robinson, 432 F.2d 977, 980-81 (4th Cir. 1970); Virginia Petroleum Jobbers Ass'n v. Federal Power Commission, 259 F.2d 921, 927 (D.C. Cir. 1958); and see Environmental Defense Fund, Inc. v. Froehlke, 368 F.Supp. 231, 256 (W.D. Mo. 1973), aff'd, 497 F.2d 1340 (8th Cir. 1974).



law. I do so, however, with reluctance and with a determination to put before the Legislature in the near future a number of proposed changes designed to meet the objections raised by the Departments of Health and Social Services and to insure that the Medicaid program in this State can be effectively and fairly administered." (Emphasis supplied.)

Session Law News of New York (McKinney, May 10, 1976) at A-251.

Despite this undertaking by the Governor to submit corrective legislation to the Legislature which might well have accomplished the State's purposes of saving money as well as obviating the need for this litigation, the Governor has submitted no new proposals to the State Legislature. Under the circumstances the District Court cannot be faulted for determining that the interest of the State in avoiding a preliminary injunction is outweighed by the interests of plaintiffs in obtaining and performing medically needed surgery.

CONCLUSION

For the reasons stated herein it is respectfully requested that the District Court's Order be in all respects affirmed.

Dated: New York, New York  
April 13, 1977

Respectfully submitted,

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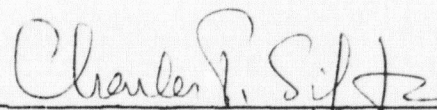


CERTIFICATE OF SERVICE

I, Charles P. Sifton, a member of the bar of this court, hereby certify that on this 13th day of April, 1977, I caused two copies of Brief of Plaintiff-Appellees to be delivered by hand to the following address:

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General

  
Charles P. Sifton

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APR 13 1977

NEW YORK CITY OFFICE

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*Sm*